

# Women's Reproductive Rights in Colombia: A Shadow Report

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WOMENS REPRODUCTIVE RIGHTS IN COLOMBIA  
A SHADOW REPORT

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(CRLP)

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## **Introduction**

This report is intended to supplement, or “shadow,” the report of the government of Colombia to the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW). It has been compiled and written by the Center for Reproductive Law and Policy (CRLP) and Corporación Casa de la Mujer (“Casa”). As has been expressed by CEDAW members, NGOs such as CRLP and Casa can play an essential role in providing credible and reliable independent information to CEDAW regarding the legal status and the real-life situation of women and the efforts made by ratifying governments to comply with the Convention on the Elimination of All Forms of Discrimination against Women (Women’s Convention) provisions. Moreover, if CEDAW’s recommendations can be firmly based in the reality of women’s lives, NGOs can use them to pressure their governments to enact or implement legal and policy changes.

Discrimination against women permeates all societies. Clearly, this discrimination requires urgent action. However, this report is focused particularly on reproductive rights, laws and policies related to such rights, and the realities affecting women’s reproductive rights in Colombia. As such, this report seeks to follow-up on the December 1996 “Roundtable of Human Rights Treaty Bodies on the Human Rights Approaches to Women’s Health with a Focus on Reproductive and Sexual Health Rights” held in Glen Cove, New York by bringing to the attention of treaty monitoring bodies the human rights dimensions of health issues, with a particular focus on women’s reproductive and sexual health. As articulated at the 1994 International Conference on Population and Development in Cairo, as well as the 1995 United Nations Fourth World Conference on Women in Beijing, reproductive rights consist of a number of separate human rights that “are already recognized in national laws, international laws and international human rights documents and other consensus documents,” including the Women’s Convention. We believe that reproductive rights are fundamental to women’s health and equality and that States Parties’ commitment to ensuring them should receive serious attention.

This shadow report links various fundamental reproductive rights issues to the relevant provision(s) of the Women’s Convention. Each issue is divided into two distinct sections. The first, shaded section deals with the laws and policies in Colombia relating to the issues and corresponding provisions of the Women’s Convention under discussion. The information in the first section is mainly obtained from the Colombia chapter of *Women of the World: Laws and Policies Affecting Their Reproductive Lives – Latin America and the Caribbean*, one of a series of reports in each region of the world being compiled by CRLP in collaboration with national-level NGOs. Casa collaborated with CRLP and DEMUS, Estudio para la Defensa de los Derechos de la Mujer, in Lima, Peru, on the Colombia chapter. The second section focuses on the implementation and enforcement of those laws and policies — in other words, the reality of women’s lives. Casa has provided nearly all of the information included in this section.

This report was coordinated and edited by Katherine Hall Martinez and Luisa Cabal for CRLP, with the assistance of Alison-Maria Bartolone, and by Isabel Agatón Santander for Corporación Casa de la Mujer.

## **December 1998**

## **A. Right to Health Care; Including Reproductive Health Care and Family Planning (Articles 12, 14 (2) (b), (c) and 10(h) of CEDAW)**

### **1. Access to Health Care**

#### **Laws and Policies**

As of 1991, the Colombian Constitution recognized health as a public service, and mandated that the government guarantee all individuals equal access to health services.<sup>1</sup> The government is also required to manage, direct and regulate the provision of health services in accordance with the principles of efficiency, universality and solidarity.<sup>2</sup> Health service delivery is decentralized by levels of treatment at the national and local levels in public and private health care entities. It also encompasses community involvement.<sup>3</sup>

In Colombia, the government is required to provide social security (health insurance) to all its citizens “directed, coordinated and supervised by the government.”<sup>4</sup> Based on this constitutional mandate, Congress enacted Law No. 100 in 1993, which delineates the characteristics of the national social security system. It includes provisions that guarantee that by the year 2000, health care will cover all of the population, even those who cannot pay fees.<sup>5</sup> The social security system provides for health services, including disability benefits and retirement benefits. The two systems of affiliation to the social security system are the contributory system, to which salaried workers have access, and the subsidized system, which provides coverage to the poorest segment of the population.<sup>6</sup> Within this system, both public and private entities provide health care services.<sup>7</sup>

The social security system provides services through these programs: the Compulsory Health Plan (the “Compulsory Plan”),<sup>8</sup> the Primary Health Care Plan (the “Primary Plan”),<sup>9</sup> and the Compulsory Health Plan of the Subsidized Regime (the “Subsidized Plan”).<sup>10</sup> The Compulsory Plan provides health services to all families, particularly maternal health care.<sup>11</sup> In addition to these services, pregnant women and mothers of children under one year covered by the Compulsory Plan also receive a food subsidy.<sup>12</sup> The Compulsory Plan also mandates the creation of educational programs for women dealing with comprehensive health and sex education, with special emphasis on women in rural areas and adolescents.<sup>13</sup> The Ministry of Health created the Primary Plan to complement the coverage of the Compulsory Plan,<sup>14</sup> particularly to emphasize information, education and community orientation.<sup>15</sup> It also provides coverage for family planning services and the treatment of transmissible diseases like HIV/AIDS.<sup>16</sup> Primary health care provision under this program is free of charge and mandatory.<sup>17</sup> The Subsidized Plan includes health care services for those that cannot afford the fees and yet are entitled to coverage by the Compulsory Plan. It also includes programs promoting health for women of childbearing age through family planning services, reproductive health counseling, pap smear testing, breast examinations, and programs to treat sexually transmissible infections.<sup>18</sup>

In 1993, Law No. 100 established sliding scales for subsidies, methods of payment by installments, health services packages for women, and other subsidized forms of payment, with an emphasis on primary health care services.<sup>19</sup> The paying affiliates of the social security system finance the services they receive through their health insurance fees.<sup>20</sup> The affiliates of the subsidized regime receive special treatment, as part of the strategy to incorporate the most disadvantaged sectors of the population to

social security system health coverage. In this way, Law No. 100 of 1993 provides that under the subsidized regime, the provision of services of the Primary Plan will be mandatory and free of charge, and covered by the state.<sup>21</sup> The government will only partially subsidize the primary health care services not included in the Primary Plan. Those on the Subsidized Plan pay only 50% of the amount paid for these services in the contributory system. Higher level services will be incorporated gradually with the support of the fees paid by contributors from 1993 on.<sup>22</sup>

## **Reality**

According to 1996 statistics, 97% of Colombians have access to primary health care.<sup>23</sup> In 1992, the state health system covered only 39% of the population.<sup>24</sup> During the 1990-1995 period, the public and “mixed” state and private systems provided 80% of pregnant women with prenatal care.<sup>25</sup> As for the remaining 20%, nurses provided 3% of women with such care, and 17% of women received no prenatal care at all.<sup>26</sup> Despite the fact that the health sector’s coverage and human resources are relatively high, they are generally of low quality. Furthermore, they are concentrated in certain regions. Most of the poor population is dispersed throughout the country and lacks access to these services.<sup>27</sup> Health sector reform, nevertheless, has resulted in increased health care coverage. Specifically, 1998 figures show that 20.5 million people have coverage, meaning that the number of men and women covered has tripled since 1993.<sup>28</sup> Unfortunately, the improved coverage does not correlate with high-quality services.

According to experts, reforms introduced pursuant to Law 100 have been the most complete and ambitious in Latin America, particularly given the difficulties and complexities underlying its implementation. When reforms began, less than 20% of the population was insured and the public health system lacked a tradition of efficiency.<sup>29</sup>

Health sector reforms have encountered difficulties for various reasons. These include the following: (1) unequal development of decentralized administration in territorial entities; (2) lack of expertise on management issues; (3) delays in implementing the provisions of the Primary Health Care Plan and the Compulsory Plan; and (4) unrealistic budgetary allocations to initiate the reforms. These factors have contributed to a deterioration in health-service quality, access to health services, and health professionals’ working conditions.<sup>30</sup>

It is important to note that Law 100 requires that women have equal access to health benefit plans. While 5.7 million people have subscribed to the government-subsidized plan, there is no gender disaggregated data. Thus, it is impossible to evaluate whether women are participating equitably in health programs. The Ombudsman’s 1996 report, however, concludes that access to the system has been limited and inequitable, social and community participation has not been effective, and the Compulsory Plan has been inequitable and discriminatory.<sup>31</sup>

Another issue is that health care providers are trained using concepts like “total quality” (the number of patients attended per physician) rather than ethics or human rights.<sup>32</sup> Under Law 100, this problem of nonexistent medical ethics takes on greater significance because doctors are simply considered employees whose work is measured using productivity criteria. Fees collected, time spent per patient, medications dispensed, the number of appointments, tests, and other aspects of health care

delivery are decided neither by doctors' nor patients' needs. Doctors' and hospitals' contracts require that they treat "groups of patients" without concern for the quality of care.<sup>33</sup>

In general, the plans and programs comprising the social security system have significant deficiencies. The Compulsory Plan, for example, covers only certain "essential" medications while other equally essential medicines are not covered.<sup>34</sup> Furthermore, Law 100 does not include pre-existing conditions; consequently, experts warn of seriously limited access for patients with conditions like cancer and AIDS.<sup>35</sup> Finally, serious restrictions inhibit general practitioners' ability to refer patients to specialists. In addition, clients must pay a surcharge for specialist referrals. This surcharge limits access to those who can pay and contradicts the goal of comprehensive health-service delivery.

The issue of internally displaced persons should be noted. In many parts of Colombia, people have fled to escape the violence between government and guerilla forces. Programs are being developed to address these displaced people's health needs. Nevertheless, such programs do not emphasize the specific health needs of women, though women comprise the majority of those in need of such services. To ensure health care services to displaced women, the government plans to provide free services. Specifically, such women will not have to satisfy formal income-level requirements nor make co-payments to receive services.<sup>36</sup> In practice, however, no means exist to measure either compliance with such requirements or the extent to which women would be covered.

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## **2. Access to Comprehensive, Quality Reproductive Health Care Services**

### **Laws and Policies**

In 1992, the Ministry of Health launched its policy entitled "Health for Women, Women for Health."<sup>37</sup> This policy focuses on the role of women as central decision makers and the primary providers of health care.<sup>38</sup> The policy's objectives include: improving women's quality of life; decreasing the unequal access of men and women to health services; and strengthening the role of women in the health sector by promoting their participation in decision making.<sup>39</sup> The program seeks to foster autonomy and self-care for women in terms of their bodies, their sexuality and their overall health.<sup>40</sup> Within the context of its National Development Plan for the period from 1994 to 1998, known as "The Social Leap Forward,"<sup>41</sup> the current government recently enacted the "Participation and Equality Policy for Women."<sup>42</sup> The objectives of the Participation and Equality Policy for Women are: to foster respect for the issue of the treatment of women's health issues; to promote comprehensive treatment of women's health through programs that respond to their specific needs; and to promote a greater role for women by encouraging their participation in the design, implementation and evaluation of health policies.<sup>43</sup> The specific commitments of the Ministry of Health are to: "strengthen, coordinate and supervise those policies that promote the comprehensive health and human development of women and girls; develop a program of prevention, detection and treatment of preventable STIs; and implement promotional and educational programs to foster greater male participation in issues of sexual and reproductive health."<sup>44</sup>

As a component of the Participation and Equality Policy for Women the government established the "Comprehensive Health Program for Women" based on the earlier experience of the policy initiative, "Health for Women, Women for Health."<sup>45</sup> One of the primary goals of the Comprehensive

Health Program for Women is to link low-income women to the subsidized health system in an equitable manner. It also aims to encourage self-employed women workers and domestic employees to become contributors to the social security system.<sup>46</sup> It also provides that the government must take the necessary steps to reduce unwanted pregnancies, abortions, maternal and perinatal mortality, morbidity and mortality due to breast and cervical cancer, and the transmission of sexually transmissible infections (STIs) and Human Immunodeficiency Virus (HIV)/ Acquired Immune Deficiency Syndrome (AIDS).<sup>47</sup>

The Maternal and Child Health Care Plan was created as part of the subsidized social security system to incorporate the most vulnerable groups of the population into the subsidized regime. The program, which treats pregnant women and children under the age of one, includes, among other services, treatment during pregnancy, childbirth, and the post-natal period. It also includes family planning services, reproductive health counseling, and health care for children under the age of one.<sup>48</sup>

In addition, the subsidized regime of the social security system establishes that women of childbearing age have the right to receive family planning services, reproductive health counseling, Pap smear testing, and breast examinations.<sup>49</sup> The subsidized regime's Maternal and Infant Health Care Plan includes prenatal, birth and post-natal care as well as family planning services.<sup>50</sup> It also mandates the creation of a reproductive health counseling center to implement these services.<sup>51</sup> Moreover, the Constitution provides that the government must protect and support women during pregnancy and after childbirth, as well as women heads of household.<sup>52</sup> The Subsidized social security system does not cover infertility treatments.

## **Reality**

While Colombia's maternal mortality rate is declining (1986: 1198 deaths per 100,000 live births; 1994: 98.2), it remains a serious health issue, as do problems of under-reported data.<sup>53</sup> Poor women have higher rates of morbidity and mortality.<sup>54</sup> For example, the Pacific Coast's maternal mortality rates are three times higher than the national average and nine times higher than the rate in the Medellín metropolitan area.<sup>55</sup> During the last twenty years, the age of first pregnancy has shown great variation. Educated women have tended to postpone motherhood,<sup>56</sup> while poor women have begun to have children even earlier. For females aged 10-14 and 15-19, the leading cause of hospitalization is to give birth.<sup>57</sup>

A 1995 survey found that 82.6% of women who gave birth received care from a physician, nurse, nurse's aid, or health worker during pregnancy.<sup>58</sup> During this same period, 84.6% of women were attended by a health care worker during the delivery itself.<sup>59</sup> For all births in 1995, 73.8% were attended by physicians, 10.8% by nurses, and 8.5% by midwives, while 6.6% were not attended by any trained person.<sup>60</sup> In 1991, 37% of women's deaths resulted directly from obstetric causes, while another 25% resulted from toxemia during pregnancy.<sup>61</sup>

Models for providing general, sexual, and reproductive health services in Colombia are deficient in several respects. For example: (1) women are viewed merely as reproductive beings; (2) the models fail to consider the exercise or enjoyment of sexuality; (3) women are assigned greater responsibility for regulating fertility than men; (4) both women and men have limited access to safe

and effective contraceptive methods; and (5) women's sexual and reproductive autonomy is not respected.<sup>62</sup>

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### **3. Access to Information on Health, including Reproductive Health and Family Planning**

#### **Laws and Policies**

Colombian law recognizes the right of couples and/or individuals to make informed decisions about the number and timing of children.<sup>63</sup> The policy reforms promoted by the Comprehensive Health Program for Women emphasize the legal obligation of service providers to inform service-users of their family planning options as part of the counseling process.<sup>64</sup>

Additional regulations establish the means through which members of the local community can participate in health service delivery. Such regulations seek to assist service-users in the exercise of their rights and in their participation in the management of existing health plans and programs.<sup>65</sup> They mandate that healthcare establishments provide service-users with regular information and care.<sup>66</sup> They also propose the creation of associations of service-users.<sup>67</sup> These associations report on the quality of the services provided, respond to the complaints of service-users, and supervise and control the performance of health care establishments.<sup>68</sup> The law also provides for community control of health care provision through oversight committees,<sup>69</sup> comprised of citizens and institutions at the community level, to oversee health service delivery.<sup>70</sup>

#### **Reality**

In a 1995 demographic and health survey, seven of every ten women reported having seen or heard family planning messages during the preceding six months, principally through either radio and television (34%) or television alone (28%).<sup>71</sup> Of women who had not heard such messages, most lived in rural areas and had the lowest levels of formal education. The vast majority of women (98%) approve of disseminating family planning messages by radio, television, and print media.<sup>72</sup>

While women have a high degree of knowledge about different family planning methods, this fact does not mean that women have accurate information about these methods, their use, or their contraindications.<sup>73</sup> In rural areas, for example, 58% of women using the pill do so incorrectly. Furthermore, 60% of them believe the pill has grave health effects. Finally, 75% obtain the pill directly from pharmacies, meaning that many women either lack adequate instruction about using the pill or have difficulty understanding the printed instructions accompanying it.<sup>74</sup>



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## **4 Contraception**

### **Laws and Policies**

The Code of Medical Ethics enshrines the physician's obligation to obtain the patient's consent before administering any treatment or performing any procedure.<sup>75</sup> In addition, the code regulates the rights of patients in their relationship with the physician.<sup>76</sup> Furthermore, patients having irreversible contraceptive procedures performed must give their informed and voluntary consent after being informed about the procedure to be performed.<sup>77</sup> This regulation also mandates that any establishment that seeks to provide fertility regulation services is part of the medical profession and must therefore abide by the ethical norms established by that profession.<sup>78</sup>

In terms of population and family planning policies, one of the main objectives of the Ministry of Health is to increase the prevalence of contraceptive methods and family planning counseling. Its specific goal in this regard is to increase the impact of state health care providers on the rate of total contraceptive prevalence from 30% in 1994 to 60% by the year 2000. This would bring the total level of public and private impact on the rate of contraceptive prevalence to between 70 and 72% by the year 2000.<sup>79</sup>

Family planning services are a component of the primary health care program,<sup>80</sup> and every health center and hospital must provide family planning services to low-income individuals.<sup>81</sup>

The National Food and Drug Administration ("NFDA") is charged with ensuring quality control over pharmaceutical products.<sup>82</sup> This entity implements policies formulated by the Ministry of Health that deal with the safety and quality control of drugs and contraceptive devices such as condoms and diaphragms.<sup>83</sup>

### **Reality**

According to government information sources, the state has supported family planning services and incorporated them in population policy for many years.<sup>84</sup> In 1993, nevertheless, the state system covered only 20% of contraceptive methods countrywide.<sup>85</sup> With respect to all contraceptives distributed, the Ministry of Health provides the following quantities: 53% of IUDs, 25.2% of birth-control pills, 25.2% of sterilizations, and 7% of condoms.<sup>86</sup> Government hospitals and clinics offer these services in both rural and urban areas.<sup>87</sup>

In practice, private-sector organizations such as PROFAMILIA provide the majority of family planning services.<sup>88</sup> PROFAMILIA, in fact, supplies 70% of the demand for modern methods. The most common places people mention for obtaining contraceptives are drugstores, PROFAMILIA, and hospitals.<sup>89</sup> The public sector supplies 27.2% of all contraceptive methods, while the private sector provides 72.1%. In 1997, an estimated 1.8 million women did not obtain needed family planning services.<sup>90</sup>

No data exist for determining whether family planning service providers are subject to "incentives" concerning certain forms of contraception. Likewise, no data exist concerning whether providers supply contraceptive methods without obtaining the client's informed consent.

## **5. Abortion**

### **Laws and Policies**

Abortion is illegal in Colombia and is categorized by the Penal Code as a crime against life and personal integrity.<sup>91</sup> The Constitution recognizes the right to life as an inviolable fundamental right, but it does not specify whether this right becomes applicable at a particular moment during pregnancy.<sup>92</sup> However, the Constitutional Court determined in a recent case before it that human life is protected from the moment of conception.<sup>93</sup>

Criminal law penalizes a woman who induces her own abortion, as well as the person who performs the abortion with the woman's consent.<sup>94</sup> It also criminalizes the behavior of any person who performs an abortion without the woman's consent or on a woman younger than 14.<sup>95</sup> In cases of abortion when the pregnancy was the result of rape, incest or nonconsensual artificial insemination, the penalty is less severe.<sup>96</sup> The law also penalizes any person who causes injuries to a woman resulting in a miscarriage.<sup>97</sup>

A woman who induces her own abortion or who consents to its performance by another person is liable to imprisonment for one to three years.<sup>98</sup> The same penalty applies to any person who performs an abortion with the woman's consent.<sup>99</sup> Any person who performs an abortion without the woman's consent or on a minor under 14 years of age is liable for three to ten years of imprisonment.<sup>100</sup> A woman whose pregnancy was the result of rape, incest or nonconsensual artificial insemination and who induces her own abortion is liable to a reduced prison sentence of four months to one year.<sup>101</sup> The same penalty is applicable to any person who performs an abortion on a woman who became pregnant under these circumstances.<sup>102</sup>

### **Reality**

Abortion continues to be a public health problem of unknown magnitude, principally due to its illegality, which in turn contributes to substantial under-reporting. In 1995, approximately 80% of abortions were due to the absence of contraceptive methods; the remaining 20% occurred due to failures in contraceptive methods.<sup>103</sup>

According to 1993 data, approximately 450,000 abortions occur in Colombia every year.<sup>104</sup> A 1996 study of maternal mortality in Colombia<sup>105</sup> estimates that in 1994, abortion was the second-leading cause of maternal mortality, which correlates with the high rate of unsatisfied demand for contraceptive methods. The same study shows that the 20-29 age group reported the highest incidence of abortion-related deaths.<sup>106</sup> According to the President's Council on Women, approximately 20% of Colombian women of child-bearing age (about 1.5 million) had at least one abortion in 1993. This number included women of all ages and social classes, although young women aged 16-27 had the highest incidence of abortion. Women under age 15 also have abortions, and abortion is the fourth leading cause of hospitalization for this group.<sup>107</sup>

According to the latest studies in Colombia, 26 of every 100 women attending universities — more than half of whom are no older than twenty — have had an induced abortion.<sup>108</sup> The situation is

no less serious in the rest of the population. One out of every three women who has ever gotten pregnant acknowledges having had an induced abortion.<sup>109</sup> Of every 100 women who have an abortion in Colombia, 29 suffer complications, and 18 arrive at the hospital in extremely serious condition.<sup>110</sup>

According to available data on criminal prosecutions for abortion, 119 cases were filed in 1994.<sup>111</sup> Nevertheless, the number of persons acquitted or convicted for abortions is unknown, and it is not known whether women have been imprisoned for abortion.

The methods used to carry out clandestine abortions vary greatly depending on the woman's income. They range from the most modern, safe, effective, and expensive to a wide variety of traditional methods that are used either by the woman herself or an untrained person (midwives, traditional practitioners, or "back-alley" abortionists). Traditional methods include: administering drugs either vaginally or orally; ingesting herbs or hormonal products; inserting probes; and using violent techniques such as falling repeatedly or jumping.<sup>112</sup> Both the choice of method and its consequences are directly related to the type of practitioner and the social class of the pregnant woman. Poor women from both rural and urban areas suffer the most complications (50-60%) from either self-induced abortions or those performed by others.<sup>113</sup>

Given abortion's illegality and Colombian society's general condemnation of it, health care providers' response to complications arising from clandestine abortions is discriminatory, accusatory, and guilt-inducing. Some health officials report abortions to the criminal justice system. These officials do so to comply with citizens' general duty to report criminal acts of which they have knowledge.

Currently, a bill introducing modifications in the Penal Code's treatment of abortion is making its way through Congress. If this bill becomes law, it would constitute a serious step backward because it treats the fetus as the passive victim of a criminal act. The bill would modify the part of the Penal Code addressing crimes against life and persons and introduce a special chapter including all acts constituting a crime against a fetus. The basis for criminalizing such acts is that even though the fetus's life depends on its mother, the fetus itself is a human life. The bill also creates two extenuating circumstances regarding abortion: (1) pregnancies that resulted from a transfer of eggs to which the woman did not consent; and (2) the existence of medical or genetic anomalies in the fetus that are incompatible with independent life.

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## **6. Sterilization**

### **Laws and Policies**

In Colombia, the Ministry of Health regulates surgical sterilization.<sup>114</sup> The ministry's regulations mandate that those who elect irreversible methods of contraception must provide clearly documented voluntary and informed consent.<sup>115</sup> The individual may consent only after a health professional gives a full explanation of the desired surgical procedure. This explanation must include the procedure's possible side-effects, the risks and benefits of the procedure, the availability of alternative contraceptive methods, the precise purpose of the operation and its irreversibility.<sup>116</sup>

## **Reality**

Sterilization is the most common family planning method among Colombian women. In fact, one in four women using contraceptive methods chooses sterilization.<sup>117</sup> PROFAMILIA and government hospitals perform most female sterilizations and insert most IUDs. PROFAMILIA also performs most vasectomies.<sup>118</sup>

Many government institutions perform sterilizations through special contracts with PROFAMILIA. Alternatively, PROFAMILIA's doctors and surgical teams perform surgeries in public-sector institutions, especially in areas where PROFAMILIA lacks surgical facilities.<sup>119</sup>

The Ministry of Health requires that people satisfy the following conditions before they can be eligible for sterilization: (1) both men and women must be over age 30; (2) they must have a minimum of two children; (3) they must voluntarily request the procedure; (4) the person or couple must grant written authorization by completing an informed consent form that expressly describes the irreversibility of sterilization.<sup>120</sup> PROFAMILIA, for its part, requires that women be over 25 and have at least three children. Depending on particular circumstances, however, either the age or the number of children requirement may be waived. For example, for young mothers with many children or for much older women with few children, sterilizations may be performed.<sup>121</sup>

PROFAMILIA has a mobile program in which company vehicles carry groups of women to the clinic and back to their homes. Once the women reach the clinic, the procedure is virtually the same as for those women who come to the clinic on their own. The main difference between the group and individual patients is motivation. Individuals come for their own private reasons; mobile-program participants, on the other hand, usually come from remote and impoverished areas, are less informed, and lack the resources to travel to the nearest city clinic. Women in the mobile program are motivated by educational discussions that PROFAMILIA's instructors hold in communities. The content of group discussions is similar to that of private counseling sessions.

It is not known with certainty whether post-sterilization counseling occurs in public institutions. The private entities subcontracted by the government to perform sterilization, however, do offer such counseling.

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## **7. HIV/AIDS and Sexually Transmissible Infections (STIs)**

### **Laws and Policies**

The laws presently governing official HIV/AIDS<sup>122</sup> policies regulate health establishments, preventive treatments, research, and the rights and duties of persons infected with HIV/AIDS.<sup>123</sup> The law mandates that health establishments promote and implement activities aimed at providing public health care personnel with information, training and education to keep them abreast of scientific and technological advances, thus ensuring the proper treatment of HIV/AIDS.<sup>124</sup> The law also provides that these activities be directed at prevention as the most important means of controlling HIV infection.<sup>125</sup> The Ministry of Health is responsible for promoting HIV/AIDS research.<sup>126</sup> When such research involves human subjects, particularly AIDS patients, it must be consistent with the provisions of the Helsinki Declaration of the International Medical Association.<sup>127</sup> Colombian law also requires

all government institutions, organizations, departments, areas and ministries, especially the Ministries of Communications, Health and Education, to promote educational campaigns related to HIV/AIDS.<sup>128</sup>

With respect to the rights of persons with HIV/AIDS, the law provides that public and private health establishments must provide comprehensive treatment to such persons as well as to any person at risk of contracting HIV/AIDS.<sup>129</sup> This treatment must be provided with respect for the dignity of the patient, without any discrimination, and in accordance with the technical and administrative regulations and the standards of epidemiological control issued by the Ministry of Health.<sup>130</sup> The law also states that criminal charges may be brought against a person who, after having been informed that he or she is infected with HIV, deliberately engages in practices that might expose other persons to infection, or donates blood, semen, organs or other body parts, for the crime of “propagating an epidemic” or for violating health regulations as established in the Penal Code.<sup>131</sup>

Employees are not required to inform their employers that they are HIV-positive.<sup>132</sup> Moreover, prisoners cannot be forced to have an HIV test except when such a test will serve as probative evidence in a criminal trial or by order of the competent health authorities.<sup>133</sup>

In 1993, Colombia issued the “Inter-ministerial Medium-Term Plan to Control and Prevent STIs and HIV/AIDS” (the “STI and HIV/AIDS Plan”), an inter-ministerial policy on HIV/AIDS control and prevention based on strategies of health promotion, HIV/AIDS prevention, epidemiological monitoring and the reduction of the social and economic impact of HIV/AIDS.<sup>134</sup> The objective of the STI and HIV/AIDS Plan is “to foster awareness among the individual, the family and society at large regarding the different forms of transmission of HIV/AIDS and other STIs; to promote values, attitudes and conduct that will ensure the exercise of responsible sexual behavior; to strengthen and develop programs aimed at preventing and controlling HIV/AIDS and other STIs and reducing their social and economic impact.”<sup>135</sup>

The plan emphasizes the following strategies: the promotion of sexual health and the prevention of transmission through sexual contact, pregnancy, as well as through transfusions of blood and blood derivatives, organ transplants or other invasive procedures. It also emphasizes the prevention of transmission through syringes and needles, epidemiological control and research on STIs/HIV/AIDS, and the reduction of the social and economic impact of the illness through the monitoring and evaluation of its development.<sup>136</sup> The subprogram on sexual health promotion seeks to develop intervention strategies, such as regional and local programs designed to prevent STIs/HIV/AIDS, directed at specific groups of the population, including men and women of childbearing age, adolescents who attend school as well as those who do not, teachers, and health care personnel. These intervention strategies seek to improve information, educational and training services.<sup>137</sup> **Finally, the sub-program on the economic impact of the disease aims to make the appropriate adjustments in those health services that respond to the HIV/AIDS epidemic, with special emphasis on the comprehensive care of persons with HIV/AIDS. It also seeks to prioritize the needs of individuals from the poorest sectors of society, including those who receive benefits from the subsidized social security regime.**<sup>138</sup>

## **Reality**

Through 1994, Colombia reported 85 cases of HIV/AIDS per one million inhabitants.<sup>139</sup> Data from 1992 showed 2,855 cases of AIDS in men and 212 in women.<sup>140</sup> In 1993 there were 2,855 cases of HIV and 3,304 of AIDS.<sup>141</sup> Given under-reporting and the fact that the social security system still does not include everyone, it is believed that rates are much higher than those officially reported. Discrimination in health services exists against people, whether male or female, suffering from HIV/AIDS or STIs. This discrimination denotes prejudice about and a lack of open discussion about sexual differences generally. No data exist to determine either the number of discrimination cases or of official responses to sanction abuses and discriminatory practices. When either patients' or their families' rights are violated, they can seek redress through a *tutela* claim.<sup>142</sup> In order to receive medical attention for AIDS within the social security system, people must pay into the system for one hundred weeks (two years). This requirement means that many people are not covered.<sup>143</sup>

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## **8. Adolescent Reproductive Health**

### **Laws and Policies**

The Health for Women, Women for Health Program initiated in 1992 targets in particular women between the ages of 15 and 49, especially adolescent women.<sup>144</sup> As part of the Participation and Equality Policy for Women the government has proposed including the prevention of abortion and unwanted pregnancies through the design and implementation of appropriate family planning programs.<sup>145</sup>

### **Reality**

Approximately one of every ten Colombian women reports having had her first sexual experience before age 15.<sup>146</sup> One third of women have had their first experience before age 18, and slightly more than half before age 20.<sup>147</sup>

Currently, only 11% of women between ages 14 and 19 use contraceptive methods.<sup>148</sup> Of this group, 14% are mothers.<sup>149</sup> The average age when women first give birth is directly related to their educational level.<sup>150</sup> Specifically, women with low levels of education average 19 years of age, while women with secondary education average 23 years.<sup>151</sup> In 1995, 31% of live births among adolescent women resulted from pre-marital sexual relations.<sup>152</sup>

Pregnancy at a young age is part of the cultural heritage in some regions. In most cases, however, these pregnancies are unwanted and involve single mothers who have usually been abandoned by their partners.<sup>153</sup> Furthermore, many of these pregnancies end in costly clandestine abortions performed under inadequate conditions.<sup>154</sup> Of every 100 women who become pregnant before age 19, 45 have an abortion. According to hospital records, abortion is the third leading cause of maternal mortality among adolescents.<sup>155</sup>

Health care providers generally hold moralistic views that prevent a comprehensive approach to addressing the health effects of adolescent sexual activity. Adolescents are therefore inhibited from consulting providers about their reproductive and sexual health problems or concerns. Likewise, adolescents feel inhibited about seeking medical care for STIs. The idea that sexual activity is “for adults only” still exists. Consequently, the corollary that young people should not be provided with information on family planning methods exists as well.

In practice, male and female adolescents lacking economic resources do not have adequate access either to reproductive health care or to contraceptive methods. The government does not cover such services. However, some private health care organizations such as PROFAMILIA offer these services on a sliding fee scale to adolescents.

When adolescent women become mothers, they often suffer discriminatory treatment in educational institutions; some have even been expelled. It is important to note that *tutela* claims have played an important role in defending against discrimination due to adolescent pregnancy. Several cases have held that pregnancy is a legitimate exercise of the free development of one’s personality and that discrimination in education is not justified.<sup>156</sup> Nevertheless, government authorities need to improve procedures for investigating discriminatory acts within educational establishments and for insuring compliance with judicial decisions prohibiting such discrimination.

## **B. Family Relations (Article 16 of CEDAW)**

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### **1. Marriage and Domestic Partnership**

#### **Laws and Policies**

The Constitution states that the basic unit of society is the family. The family is formed by the free decision of a man and a woman to marry, or by the responsible decision of a man and a woman to establish a family.<sup>157</sup>

The civil law<sup>158</sup> provides that marriage is a solemn contract in which a man and a woman unite with the objective of living together, procreating, and giving each other aid.<sup>159</sup> A marriage becomes legal when the two persons express their mutual and voluntary consent to marry before a competent authority.<sup>160</sup> The minimum age of marriage is 18.<sup>161</sup> A woman may decide whether or not to adopt her husband’s surname.<sup>162</sup> Spouses are obligated to be faithful and to aid and assist one another.<sup>163</sup> Both spouses have the joint right to administer the household,<sup>164</sup> the authority to choose their place of residency, and the duty of contributing to the household economy according to their abilities.<sup>165</sup> The mother and father share parental authority<sup>166</sup> over their children,<sup>167</sup> and either parent can act as the legal representative of his or her children.<sup>168</sup>

Civil law establishes equality between spouses, and the full legal capacity of a married woman to manage her property and the couple’s jointly owned property, to enter into contracts, and to access the courts.<sup>169</sup> In 1996, Congress passed a law that requires the signature of both spouses when transferring immovable property pertaining to the family domicile.<sup>170</sup>

Law No. 54 of 1990 formally recognized a form of legal union, *union de hecho* or domestic partnership, which it defines as a stable union between an unmarried man and an unmarried woman who form a permanent household together.<sup>171</sup> The law states that, for legal purposes, the man and woman who form part of a domestic partnership are “permanent companions.”<sup>172</sup> A domestic partnership exists once the two unmarried individuals have lived together for more than two years and as long as no impediment exists that would not permit either of the companions to marry.<sup>173</sup> Any property or capital derived from work belongs jointly to both permanent companions.<sup>174</sup>

Labor laws provide that a permanent companion has the right to the retirement or disability pension of the other as well as to death benefits payable upon an employee’s death, provided the permanent companions lived together for at least two years or if they had one or more children together.<sup>175</sup> At the same time, the permanent companion of the employee or pensioner is also entitled to health care benefits from whichever entity is the provider, provided the permanent companions have lived together at least two years.<sup>176</sup>

### **Reality**

In 1995, the average age of Colombian women at first marriage was 21.4;<sup>177</sup> the average age at first childbirth was 22.1.<sup>178</sup> Educational levels are highly correlated with these ages. On average, for example, women who have attained a secondary education and are between the ages of 30 and 34 enter into marriage ten years later than women of the same age who have at most a primary education.<sup>179</sup> Place of residence also affects the average age of marriage. In urban areas, the average age is 22; in rural areas, 20.<sup>180</sup>

*Tutela* claims have been the judicial mechanism that has guaranteed some rights for women in domestic partnerships. Recently, for example, the Constitutional Court, which reviews *tutela* decisions of lower courts, has recognized that female domestic partners provide economic value through their domestic work.<sup>181</sup>

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## **2. Divorce and Child Custody**

### **Laws and Policies**

Civil marriage in Colombia terminates upon the death of one of the spouses or by a judicial decree of divorce.<sup>182</sup> The legal rights and duties of a religious marriage also cease upon legal divorce.<sup>183</sup> Grounds for divorce include: adultery; failure to fulfill one’s duty as a spouse or as a mother or father; cruel treatment; the habitual and unjustified use of alcohol or drugs; a grave and incurable illness that endangers the physical or mental well-being of the other spouse; conduct on the part of a spouse that corrupts or perverts the other spouse or one of their children; physical separation of the spouses for more than two years; and the mutual consent of both spouses before an authorized judge.<sup>184</sup>



Once the divorce has been granted, the marriage is dissolved as is any joint ownership of property which then must be liquidated according to the law.<sup>185</sup> Each spouse receives one-half of any remaining property.<sup>186</sup> The “innocent” spouse may revoke any gifts made during their marriage to the “guilty” spouse.<sup>187</sup>

A judge grants custody and parental authority over the children.<sup>188</sup> The judge also determines the amount of child support<sup>189</sup> and alimony.<sup>190</sup> The Penal Code establishes penalties for parents who fail to pay alimony or child support.<sup>191</sup> Colombian law includes several provisions regarding the amount of child support and the type of civil legal procedures that must be followed to enforce this obligation.<sup>192</sup>

### **Reality**

The person declared innocent in a divorce case has the right to receive alimony from the person declared culpable. Procedures exist for enforcing this right either before judicial authorities or in negotiations during a “conciliation” hearing. In practice, however, agreements are not kept in good faith, and failure to comply and fraud with respect to judicial resolutions often occur. Furthermore, noncompliant parties conceal both their true salary information and assets that would guarantee fulfillment of alimony obligations.

In 1996, Law 311 was passed to curtail such practices; specifically, the law established the National Registry for Protection of the Family (NRPF). The NRPF seeks to identify those who avoid alimony obligations and to enforce compliance.<sup>193</sup> Two years after the NRPF’s creation, however, the results of its efforts are unknown. Furthermore, no mechanisms for assessing its operations and effectiveness exist.

Before Law 1 was passed in 1976, a wife’s adultery — but not her husband’s — was considered grounds for separation and divorce. Law 1 repealed this inequity by defining adultery as “extramarital sexual relations of one of the spouses, unless the petitioner has consented to, facilitated, or forgiven such relations.”<sup>194</sup> In spite of this change, judges continue to view women’s extramarital sexual activity more harshly than men’s.

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## **3 Early Marriage**

### **Laws and Policies**

The minimum legal age to marry is 18.<sup>195</sup> However, men over the age of 14 and women over the age of 12 may marry with the consent of their parents.<sup>196</sup> Marriages between a man under the age of 14 and a woman under the age of 12, or when either the man or the woman is under these respective ages, are null and void.<sup>197</sup> However, marriage of an underage person is not null and void if its validity has not been questioned within three months after the minors reach puberty, or when the woman, even if she is underage, or is pregnant.<sup>198</sup>

## **Reality**

Marriage rates among female adolescents are increasing. In 1995, 16.5% of female adolescents were married, compared with a percentage of 14.2% in 1986.<sup>199</sup>

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## **4 Right to access Family Planning without Spousal Consent**

### **Laws and Policies**

Spousal consent is not needed to obtain contraceptives.

## **Reality**

There is no legal requirement of authorization from either a spouse or domestic partner to receive contraceptives. Nevertheless, some women — particularly in rural areas — report that their partners oppose contraceptive use.<sup>200</sup>

## **C. Sexual Violence Against Women (Articles 5, 6 and 16 of CEDAW)**

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### **1. Rape and Sexual Crimes**

#### **Laws and Policies**

Colombian law was recently modified<sup>201</sup> to increase the penalties for rape and to change the classification of crimes considered attacks against “sexual freedom and human dignity.”<sup>202</sup> Penal law classifies these crimes in three categories: rape,<sup>203</sup> abusive “sexual acts,”<sup>204</sup> and “statutory rape.”<sup>205</sup> The law divides rape into three sub-categories. These are: “violent carnal access” (which carries a penalty of 8 to 20 years imprisonment);<sup>206</sup> a “violent sexual act” (which carries a penalty of 4 to 8 years imprisonment);<sup>207</sup> and a sexual act with a person who is incapable of resisting (which carries a penalty of 4 to 10 years imprisonment).<sup>208</sup> An “abusive sex act” includes abusive “carnal access” with a person who is incapable of resisting and carries a penalty of three to 10 years of imprisonment.<sup>209</sup> The offender is liable for harsher penalties for these crimes if one of the following aggravating circumstances is present: more than one persons participated in the crime;<sup>210</sup> the offender has some degree of authority over the victim;<sup>211</sup> the victim becomes pregnant as a result of the rape;<sup>212</sup> the victim contracts a venereal disease; or the victim is under the age of 10.<sup>213</sup>

Law No. 360 of 1997 repealed the provision in the Penal Code establishing that an offender could be exculpated from liability for such crimes if he married the victim.<sup>214</sup> Another positive legislative development is that in 1996, rape within marriage became a criminal offense.<sup>215</sup>

The penal law for crimes against “freedom and human dignity”<sup>216</sup> provides that a person convicted of “carnal access” with a person under the age of 14 is liable to four to ten years imprisonment.<sup>217</sup> An offender who uses violence to obtain “carnal access” to a person under the age of 12 is liable to twenty to forty years of imprisonment.<sup>218</sup> An offender who carries out a “sex act” other than intercourse with a person under the age of 14 is liable to two to five years of imprisonment.<sup>219</sup>

The Penal Code also classifies statutory rape, which is the use of deception to obtain “carnal access” or another sex act with a person between the ages of 14 and 18, as a crime.<sup>220</sup> An offender who uses deception to obtain “carnal access” is liable to one to five years of imprisonment.<sup>221</sup> An offender who uses deception to carry out a “sex act” is liable to six months to two years imprisonment.<sup>222</sup> Colombian penal law also considers incest as a crime against the family.<sup>223</sup> Incest consists of “carnal access” or any other sex act with a direct descendant or ascendant, adoptive parent or adopted child, or with a brother or sister.<sup>224</sup> The penalty for the perpetrator of such a crime is six months to four years imprisonment.<sup>225</sup> Other sexual crimes under Colombian penal law include “fostering the prostitution of minors”<sup>226</sup> and “fostering the use of minors in pornography.”<sup>227</sup> Offenders are liable to two to six years imprisonment and four to ten years imprisonment, respectively.<sup>228</sup>

Since 1997, the National Council on Equality for Women (*Dirección Nacional de Equidad para las Mujeres*) has coordinated a task force concerning “Revisions in Procedures for Victims of Sexual Abuse.” Various public and private entities have participated in this task force. The task force’s primary goal is to improve protection and assistance given to domestic abuse victims by integrating and coordinating the institutions responsible for such cases. To respond to the problem of trafficking in persons, the Ministry of Justice has created the Inter-Institutional Committee to Combat the Trafficking of Women, Girls, and Boys.<sup>229</sup>

The President’s Council on Human Rights is developing strategies to sensitize and train national police officials about sexual and reproductive rights; these efforts also focus on improving the quality of assistance for victims of sexual and familial abuse.

## **Reality**

One third of women living in couples have been victims of verbal abuse;<sup>230</sup> furthermore, one in five women has suffered physical abuse,<sup>231</sup> while 6% have suffered sexual violence.<sup>232</sup>

In Colombia, 5.3% of women of child-bearing age report that they have been forced to have sexual relations.<sup>233</sup> In most cases, the women know the person responsible. Specifically, 44% of women identify their spouse or partner as the person responsible, 20% identify neighbors or friends, 14% did not know their attacker, 14% named relatives, 2% named supervisors or co-workers, and 7% named others.<sup>234</sup>

On average, the first incident of abuse occurs at age 18.7.<sup>235</sup> Sexual violence varies only slightly by region. The rate in urban areas is 6%, while that in rural areas is 4%.<sup>236</sup> In 1995, the Institute of Legal Medicine (*Instituto de Medicina Legal*) received reports of 11,970 sex-crime cases under investigation throughout the country.<sup>237</sup>

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For women between the ages of 14 and 19, the first incident of sexual abuse occurs on average at age 14.<sup>238</sup> The percentage of those abused at that age is 3.1%.<sup>239</sup> The principle persons responsible for these violations are as follows: boyfriends, friends, or neighbors (39%); relatives (26%); unknown persons (16%); and others (10%).<sup>240</sup> For adolescent rape victims, the average age at the time of the first rape diminishes in direct relation to educational levels. Specifically, the average age for women without education is 13, while the average age for those with several years of secondary education is 17.<sup>241</sup>

In 1997, the Institute of Legal Medicine identified 11,048 cases of sexual violence. Of these cases, 81.6% involved female victims. Furthermore, 26.7% of all cases occurred among the 10-14 age group. For cases involving minors, 80% of aggressors were known by the victims. These known aggressors can be broken down as follows: the father (16.2%), the stepfather (13.1%), some other family member (15.4%), and other known persons (35.3%).<sup>242</sup>

A recent study concerning sexual and familial abuse in three cities analyzed 115 cases involving sexual crimes. Of these cases, 91.6% of the victims were young girls. The presumed aggressor in these cases was often the father (31.1% of cases) or the stepfather (28.5%).<sup>243</sup>

Despite government efforts to address domestic violence, such efforts fail to address the issue in an integrated and systematic way. Efforts are particularly insufficient in two respects: compensating victims and humanizing their treatment within the criminal justice system.

While recent changes have increased penalties for sexual crimes, serious difficulties remain in the ways such crimes are investigated. Specific problem areas include procedural issues, evidentiary issues, and lack of respect for victims' rights.<sup>244</sup> In addition, authorities lack the technical and economic resources needed to conduct investigations, and the existing institutional infrastructure is not adequate for proper investigations.<sup>245</sup>

Currently, a Penal Code reform bill is making its way through Congress.<sup>246</sup> If approved, this bill would constitute a significant step backward compared to the advances of recent years. Specifically, the bill proposes shortening the maximum sentences for certain cases; it also shortens the minimum sentences for certain sexual crimes, which would result in early release for convicted perpetrators. This bill demonstrates that legislators underestimate the impact of sexual crimes, thus undermining individual responsibility and the deterrent effect of punishment.

Some judges' approach to sentencing sexual aggressors perpetuates prejudices such as the belief that women cause sexual violence by acting provocatively.<sup>247</sup> Furthermore, other stereotypes continue to prevent equal justice for women in the judicial system. Specifically, protection is limited according to subjective judgments of the woman's "honesty" or "good name," as well as the belief that women are not credible witnesses, particularly when the aggressor is a family member or otherwise known to her.

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## **2. Domestic Violence**

### **Laws and Policies**

The Colombian Constitution provides that domestic violence in any form is destructive of family harmony and unity and will be punished according to the law.<sup>248</sup> Following this constitutional mandate, Congress enacted Law No. 294 in 1996 whose objective is to penalize and provide a remedy for domestic violence. Congress also ratified the Inter-American Convention on the Prevention, Sanction and Eradication of Violence Against Women, which is now incorporated into Colombian domestic law.<sup>249</sup>

Law No. 294, which implements the constitutional mandate to provide comprehensive treatment for different types of domestic violence,<sup>250</sup> provides that physical, psychological or sexual abuse against a family member is a crime.<sup>251</sup> A person who inflicts physical or psychological injury on a family member is punished in accordance with the penalty established in the Penal Code for personal injury, plus an additional one-third of half the penalty because the situation involves domestic violence.<sup>252</sup> This law also establishes the penalties applicable to a person who uses unjustified force to restrain the freedom of movement of an adult family member.<sup>253</sup> In addition, the legislation establishes mechanisms for the provisional and permanent protection of abused persons with the objective of ending the abuse, and preventing and punishing domestic violence.<sup>254</sup> This law empowers the Colombian Institute of Family Welfare<sup>255</sup> to develop programs to prevent and remedy domestic violence.<sup>256</sup> It also provides resources to state and city governments to establish Family Violence Prevention Councils to study the problem of domestic violence and to promote activities designed to prevent and treat domestic violence.<sup>257</sup> The National Development Plan establishes that the government must improve the training of law enforcement personnel that deal with domestic issues and of the justices of the peace in dealing with the problem of violence against women.<sup>258</sup>

### **Reality**

In 1997, 145 homicides resulted from domestic violence.<sup>259</sup> Of these homicides, 57% of the victims were women.<sup>260</sup> According to 1995 statistics, women living with a partner suffered abuse as follows: 33% suffered verbal abuse from their partner or spouse; 19% suffered physical abuse<sup>261</sup>; and 6% suffered sexual abuse.<sup>262</sup> In 1995, the Institute of Legal Medicine recorded 42,963 cases involving injury due to domestic violence.<sup>263</sup>

The available data concerning domestic violence represent only a small part of the problem's true magnitude. No definitive estimates about under-reported data exist. Nevertheless, some data do indicate that although women know the institutions where they can file domestic violence complaints against their husbands, only 27% of victims have done so.<sup>264</sup> Thus, a more accurate estimate of the problem's extent would mean multiplying existing data by four.

In 1994, the Institute of Legal Medicine received an average of 93 domestic violence cases per day, 75% of which resulted from spousal problems.<sup>265</sup> In 1997, the number of domestic abuse cases increased by 40%. Of these cases, 16% involved abuse of minors, the greatest number of victims appearing in the 5-14 age group, equally divided between males and females. For victims aged 15 to 17,

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the proportion of females is the same as that of males.<sup>266</sup> Of all the people treated for domestic violence by the Institute of Legal Medicine in 1997, 93% were women, the largest group being those between the ages of 25 and 34.<sup>267</sup>

According to cases evaluated by the National Institute of Legal Medicine and Forensic Sciences, women accounted for 47% of cases involving non-fatal injuries in 1997. The causes of these injuries were categorized as follows: spousal violence (36%), common situations involving violence (32%), traffic accidents (15%), and sexual crimes (10%).<sup>268</sup>

Family- or civil-court judges can issue several forms of protective orders to address domestic violence. These include: orders removing someone from the home; orders for education and therapy; orders to pay damages; and orders providing police protection.<sup>269</sup> The police also have mechanisms for assisting victims of abuse aimed at preventing repetition of abusive behavior.<sup>270</sup> Unfortunately, however, these judicial and police measures are not adequately implemented, as evidenced by the high incidence of violent acts, police officials' lack of training, and the general unavailability of police officers to address domestic abuse issues. Furthermore, these measures do not actually protect victims from violence,<sup>271</sup> and judges do not issue orders as quickly as necessary.<sup>272</sup>

The law provides that as a temporary measure, judges can order housing for victims of domestic violence in half-way houses or shelters. Such orders, however, rarely occur because few shelters exist and most of these cater principally to minors. The shelters are usually administered by NGOs without government aid.

Currently, Congress is considering a bill that would eliminate the judiciary's jurisdiction over domestic violence. This bill, which would transfer jurisdiction for domestic violence to administrative courts such as the *Comisaría de Familias*, would have serious consequences if it becomes law. The bill reflects the assumption that family violence is a private matter. As a private matter, the thinking goes, domestic violence should not enter a public forum, merit penal sanctions, or be addressed by the judicial system.

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### **3 Violence and/or Coercion in Health Services**

#### **Laws and Policies**

Such practices are not punishable by law. No policies exist to make reparations for them.

#### **Reality**

Health care facilities' physical structures and infrastructure are inadequate for providing proper care for women; this inadequacy is particularly apparent in birthing rooms.<sup>273</sup> Health care facilities and the Ministry of Health (through its Division of Community Care) have only just begun to institutionalize a culture fostering equitable treatment and respect for patients' rights. Clients have sought to secure their fundamental rights through the judicial mechanism of *tutela* claims. In many cases, these lawsuits have been successful.

## **D. Education and Adolescents (Article 10 of CEDAW)**

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### **1. Access to Education**

#### **Laws and Policies**

The Constitution provides that children have the following fundamental rights: the rights to life, physical integrity, health, education and culture, recreation, and the right to express freely their opinions.<sup>274</sup>

Women were first granted access to higher education in Colombia in 1933.<sup>275</sup> The Constitution establishes that education is a right and a public service designed to provide access to knowledge, science, technology and other cultural goods and values.<sup>276</sup> The government, society and the family are responsible for education, which is compulsory for children between the ages of 5 and 15. Education is free of charge in public schools.<sup>277</sup>

The Colombian government is currently implementing a project entitled “Education for Equality” whose main objective is to modify the educational system so that it does not foster socialization patterns that reinforce inequity between the sexes and gender stereotypes.<sup>278</sup> It also seeks to promote equal access to education for boys and girls, and to identify the factors that limit girls’ access to education.<sup>279</sup>

#### **Reality**

The illiteracy rate among women has decreased from 29% in 1964 to 11.6% in 1993.<sup>280</sup> At almost every educational level, enrollment is equally distributed by sex. In fact, the percentage of female students enrolled in higher education has climbed to 51.7%,<sup>281</sup> much higher than the 1960 level of 18.4%.<sup>282</sup> Between 1989 and 1991, females represented 50% of preschool students and 49.2% of secondary-education students.<sup>283</sup> In the under-24 age group, men and women have completed a similar number of years of schooling. Specifically, women have completed 5.8 years, while men have completed six.<sup>284</sup> Rural women have less access to education than urban women.<sup>285</sup>

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### **2. Information and Education on Sexuality and Family Planning**

#### **Laws and Policies**

The Ministry of Education has enacted a regulation regarding the compulsory nature of sex education.<sup>286</sup> This regulation provides that, upon the initiation of the academic year in 1994, establishments throughout the country that offer programs of pre-school, primary, high school and vocational education must incorporate mandatory sex education programs as essential components of public education.<sup>287</sup> Pursuant to this mandate, the Ministry of Education designed the National Plan on Sex Education, whose objectives include: to foster changes in the values and behavior relating to

sexuality;<sup>288</sup> to reformulate the traditional definition of gender roles;<sup>289</sup> to encourage changes in the traditional family structure with the aim of promoting greater equality in the relationships between parents and children and between spouses;<sup>290</sup> and to ensure that men and women make voluntary and informed decisions about when they want to have children and that they know how to use contraceptive methods properly.<sup>291</sup>

With the aim of providing methodological tools to the National Program on Sex Education, the Ministry of Education has published a series of 11 texts to be incorporated into the curriculum at the pre-school, primary and high school level.<sup>292</sup> These texts include themes relating to personal identity, respecting others, tolerance, reciprocity, life, tenderness, dialogue, love and sex, responsibility and creativity. All of these issues then form part of the curriculum starting at first grade through the eleventh grade of instruction.<sup>293</sup>

The Ministry of Education is developing a program entitled Sexual and Reproductive Health Education of Adolescents and for Adolescents, which is directed toward young men and women between the ages of 14 and 20. It targets adolescents both in and out of school and members of youth organizations.<sup>294</sup>

## **Reality**

The results of the recent evaluation of the National Plan on Sex Education, which is administered by the Ministry of Education's Vice-Ministry of Youth, have not yet been revealed. In any event, the great limitation of such programs is that they reach only those young people attending school, whether in urban or rural areas. Consequently, they fail to reach a large number of adolescents who do not attend school.

It is also important to note that although the sex education plan has served as a model for other countries, it has several limitations. These limitations include insufficient textbooks and educational materials as well as slow incorporation of gender perspectives.<sup>295</sup>

To address the problem of pregnant adolescents enrolled in school, the Ministry of Education (through its Vice-Ministry of Youth) is trying to implement programs to foster respect for pregnant adolescents. However, no systematic evaluative procedure exists for determining how well educational institutions incorporate such programs. When institutions have not responded either to judicial or administrative authorities, numerous *tutela* claims have been filed. As a result of these lawsuits, the Constitutional Court has recognized the educational rights of minors who have been expelled from school for pregnancy.<sup>296</sup>



## E. Employment Rights (Article 11 of CEDAW)

### 1. Protection in Pregnancy

#### Laws and Policies

The Colombian Constitution provides that work is a right and a social duty that enjoys government protection.<sup>297</sup> At the same time, one of the fundamental principles of labor law is the special protection bestowed on women and maternity.<sup>298</sup> The Constitution guarantees the right of all persons to social security, with preference granted to women heads of household, pregnant women and women who are breast-feeding.<sup>299</sup>

Colombia labor legislation protects pregnant women. No employee can be terminated for being pregnant or for breast-feeding.<sup>300</sup> The law presumes that an employee was terminated because of pregnancy or breast-feeding when this dismissal occurs without official authorization during the woman's pregnancy or in the three months following childbirth.<sup>301</sup> If such a termination occurs, it is null and void, and the woman must be reinstated to her employment following the maternity leave to which she is entitled.<sup>302</sup> Since 1994, the practice of forcing women to submit to a pregnancy test before being hired has been prohibited, except when the work to be undertaken is categorized as involving high-risk activities.<sup>303</sup> An employer is obligated to relocate an employee who becomes pregnant to a position that will not expose her to substances that present a risk for her pregnancy.<sup>304</sup>

Colombian labor law prohibits the employment of minors and women of any age in activities that involve contact with substances that are potentially harmful to their health. It also prohibits assigning pregnant women to shifts longer than five hours.<sup>305</sup>

#### Reality

Pregnant women and women of child-bearing age continue to be discriminated against in the labor market. For example, companies prefer to hire men because if a female employee becomes pregnant, she is more expensive than a male employee.<sup>306</sup> Generally, women do not file complaints with the Ministry of Labor because they do not realize that they have suffered actionable discrimination, and because they fear losing their jobs. In the latter case, they prefer to keep silent and avoid calling attention to the treatment they have suffered.<sup>307</sup>

The labor rights of both pregnant women and women of child-bearing age are often violated. Legal mechanisms for addressing such violations, however, are ineffective. On occasion, women have found some success — though not consistently — through *tutela* claims.<sup>308</sup>

Several NGOs working with this problem note various common practices that violate the law. These practices involve requiring women to satisfy extralegal requirements — proving that they are not pregnant or that they use family planning methods — before they are hired.<sup>309</sup> Generally, women report that they do not file complaints about these practices because they need the job and because they do not know that such practices are illegal.<sup>310</sup> Other frequent practices that violate working

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women's rights are those associated with sexual harassment. In these cases, an immediate supervisor or foreman demands that a woman have sex in order to keep her job.<sup>311</sup> Women provide the following reasons for not filing complaints about such harassment: the difficulty of finding a solution through court proceedings, and the financial cost, the time, and the leaves of absence required for pursuing legal cases of this type.<sup>312</sup>

Among the complaints women present to the Ombudsman, those concerning violations of labor rights represent 57.8% of the total.<sup>313</sup> Nevertheless, procedures for recording and categorizing the facts presented need to be improved so that gender-based human rights violations can be recognized as such.<sup>314</sup> When information is not disaggregated by gender, issues raised by women disappear.<sup>315</sup> Failure to categorize by gender means that reliable data are not available to determine the extent of gender-based human rights violations.

There are no data concerning environmental risks to pregnant women in the workplace.

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## **2. Maternity Leave**

### **Laws and Policies**

A pregnant employee also has the right to a post-natal maternity leave of 12 weeks, during which she receives the same salary as at the time her leave began.<sup>316</sup> A woman who adopts a child under the age of seven also receives a maternity leave under the same conditions, and the date of adoption is equivalent to the date of birth.<sup>317</sup> An employee who uses her maternity leave before childbirth may reduce her leave to 11 weeks and give the remaining week to her husband or permanent companion so that he may accompany her at the moment of childbirth and immediately after delivery.<sup>318</sup> During the first six months the employer must allow a woman who has returned from her maternity leave to take two 30-minute breaks during the work day to breast-feed her child, without discounting any pay from her salary.<sup>319</sup> An employee who miscarries or whose baby dies during or after premature delivery has the right to a two to four week leave of absence, to be paid at the salary she was receiving at the time her leave began.<sup>320</sup> If a premature delivery occurs and the infant survives, the same provisions on maternity leave described above apply.<sup>321</sup>

### **Reality**

In cases where employers violate labor laws concerning either maternity leave or paid maternity leave, several legal mechanisms exist. Through these remedies, women can protect their rights using either private or administrative labor law channels. However, the average duration for such cases is two to three years. For that reason, women facing imminent danger or having already suffered a violation of their rights find a more effective approach in *tutela* claims. In some cases, these lawsuits have helped secure women's rights to maternity leave<sup>322</sup>.

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**Endnotes**

<sup>1</sup> COLOMBIA CONSTITUTION, in force as of July 4, 1991, art. 49 (hereinafter COLOM. CONST.).

<sup>2</sup> *Id.*

<sup>3</sup> *Id.* The regulations relating to territorial health entities provide that the state assemblies and the municipal councils must regulate the operations and the provision of services by such entities within their respective jurisdictions. See Law No. 60, 1993.

<sup>4</sup> Decree Law No. 1292 of 1994 (restructuring the Ministry of Health), art. 48. The same article provides that the provision of these services should be based on the principles of efficiency, universality and solidarity.

<sup>5</sup> Consejería Presidencial para la Política Social - PNR - Informe Nacional del Gobierno de Colombia - preparado para la IV Conferencia Mundial sobre la Mujer en Beijing, China [*Presidential Council for Social Policy - PNR - National Report of the Colombian Government - prepared for the IV World Conference on Women in Beijing, China*] at 55 (1994). The choice between the government and private health system is voluntary.

<sup>6</sup> *Id.*

<sup>7</sup> Law No. 100 of 1993, bk. II, art. 162, 1.

<sup>8</sup> *Id.*, art. 162.

<sup>9</sup> *Id.*, art. 165.

<sup>10</sup> *Id.*, art. 162, 1. See also Decree Nos. 1298 and 1895, of 1994, which regulate the subsidized regime of the social security system in health matters.

<sup>11</sup> *Id.*, arts. 162 and 166.

<sup>12</sup> *Id.*, art. 166.

<sup>13</sup> *Id.*, at ¶ 2.

<sup>14</sup> *Id.*, art. 166

<sup>15</sup> *Id.*, art. 165.

<sup>16</sup> *Id.*

<sup>17</sup> *Id.* art. 162. Regulations of the subsidized program is found in Decree 1895 of 1994, arts. 1-3.

<sup>18</sup> Decree 1895 of 1994, art. 11.

<sup>19</sup> "The National Board of Social Security for Health will design a program such that its beneficiaries shall enter the Compulsory Plan of the contributory system in a progressive manner before the year 2001." Law No. 100 of 1993, art. 162.

<sup>20</sup> *Id.*

<sup>21</sup> *Id.*, art. 165.

<sup>22</sup> *Id.*, art. 162.

<sup>23</sup> UNITED NATIONS POPULATION FUND, *Resource Requirements for Population and Reproductive Health Programmes - Profile Country Profiles for Population Assistance*, E/500/1996. New York, 1996, at 158.

<sup>24</sup> *Id.*, at 22.

<sup>25</sup> PROFAMILIA, ENCUESTA NACIONAL DE DEMOGRAFÍA Y SALUD [NATIONAL DEMOGRAPHIC AND HEALTH SURVEY], at 101 (1995).

<sup>26</sup> *Id.*

<sup>27</sup> United Nations, Combined Presentation of the Revised Versions of the Second and Third Periodic Reports of States Parties - Colombia, at 48-49.

<sup>28</sup> CORPORACIÓN CASA DE LA MUJER - BOGOTÁ, INFORME SOBRE LOS PROGRESOS HECHOS POR EL GOBIERNO EN RELACIÓN CON EL PLAN DE ACCIÓN DE LA CONFERENCIA DE POBLACIÓN Y DESARROLLO DE EL CAIRO 1994 [REPORT ON GOVERNMENT PROGRESS CONCERNING THE CAIRO PROGRAM OF ACTION FROM THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT 1994], at 4 (October 1998).

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<sup>29</sup> CORONA FOUNDATION. ACSSAULD, FESCOL, GTZ. EL ESTADO ACTUAL DE LA LEY 100/93 EN SALUD [THE CURRENT STATE OF HEALTH LAW 100 OF 1993], March 1997.

<sup>30</sup> *Dialoguemos... sobre Salud Sexual y Reproductiva [Let's Talk about Sexual and Reproductive Health]*, Bulletin No. 1, February 1998, at 4.

<sup>31</sup> Victor de Curra Lugo, *Derechos Humanos y Salud: La Letra Munuda de la Ley 100 [Human Rights and Health: The Fine Print of Law 100]* in *Revista Nova & Vetera*, at 67.

<sup>32</sup> *Id.*, at 70.

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> *Id.*

<sup>36</sup> CORPORACIÓN CASA DE LA MUJER, *supra* note 28, at 30.

<sup>37</sup> The Ministry of Health oversees the National Health System. This mandate is found in Decree No. 1292, 1994, which restructures the Ministry of Health.

<sup>38</sup> MINISTRY OF HEALTH, SALUD PARA LAS MUJERES, MUJERES PARA LA SALUD [HEALTH FOR WOMEN, WOMEN FOR HEALTH] (1992), at 30.

<sup>39</sup> *Id.*

<sup>40</sup> *Id.* This program seeks to reorient previous policies directed at women with the aim of institutionalizing them and improving the quality and coverage of the health system as well as strengthening women's role in promoting and understanding her health. In addition, the program outlines policies and programs aimed at promoting women's health and addressing the need for improved preventive measures and attention related to women's health. The target population of this program is women heads of family, women aged 15-49, working women, and older women.

<sup>41</sup> NATIONAL DEVELOPMENT PLAN, THE SOCIAL LEAP FORWARD (1994), Law No.188, 1995.

<sup>42</sup> NATIONAL COUNCIL OF ECONOMIC AND SOCIAL POLICY-CONPES, POLÍTICA DE PARTICIPACIÓN Y EQUIDAD PARA LA MUJER [PARTICIPATION AND EQUITY POLICY FOR WOMEN], Doc. No. 2726, at 5 (1994).

<sup>43</sup> MINISTRY OF THE ENVIRONMENT, APOYO INSTITUCIONAL A LA POLÍTICA DE EQUIDAD Y PARTICIPACIÓN DE LA MUJER-EPAM [INSTITUTIONAL SUPPORT OF THE POLICY OF EQUITY AND PARTICIPATION FOR WOMEN] (1995) at 28.

<sup>44</sup> PERMANENT MISSION OF COLOMBIA TO THE UNITED NATIONS, REVISIÓN DESPUÉS DE LA CONFERENCIA DE BEIJING. IMPLEMENTANDO EL CONTRATO CON LAS MUJERES DEL MUNDO: DE LAS PALABRAS A LA ACCIÓN [REVIEW AFTER THE BEIJING CONFERENCE. IMPLEMENTING THE CONTRACT WITH THE WOMEN OF THE WORLD: FROM WORDS TO ACTION], at 4 (1996).

<sup>45</sup> PARTICIPATION AND EQUITY POLICY FOR WOMEN, *supra* note 42, at 5 (1994); *See also* INSTITUTIONAL SUPPORT OF THE POLICY OF EQUITY AND PARTICIPATION FOR WOMEN, *supra* note 43, at 28.

<sup>46</sup> INSTITUTIONAL SUPPORT OF THE POLICY OF EQUITY AND PARTICIPATION FOR WOMEN, *supra* note 43, at 28.

<sup>47</sup> *Id.*, at 5. The same document indicates that in carrying out these steps, the government must undertake aggressive health education campaigns, improve service provision, and design programs created especially for women, including family planning services, reproductive health, and the early detection of illnesses that primarily affect women.

<sup>48</sup> Law No. 100 of 1993, bk. II, art. 12.

<sup>49</sup> Decree No. 1895, 1995, art. 11.

<sup>50</sup> *Id.*, art. 12.

<sup>51</sup> *Id.*

<sup>52</sup> COLOM. CONST., *supra* note 1, arts. 42 and 43.

<sup>53</sup> *Dialoguemos... sobre Salud Sexual y Reproductiva [Let's Talk about Sexual and Reproductive Health]*, *supra* note 30, at 2.

<sup>54</sup> NATIONAL COUNCIL ON EQUALITY FOR WOMEN, Summary Proceedings from the Workshop LA SALUD DE

LAS MUJERES EN EL MARCO DE LA LEY 100/93 [WOMEN'S HEALTH WITHIN THE FRAME OF LAW 100 OF 1993], May 1997, at 13.

<sup>55</sup> *Dialoguemos ... sobre Salud Sexual y Reproductiva* [Let's Talk about Sexual and Reproductive Health], *supra* note 30, at 2.

<sup>56</sup> NATIONAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 25.

<sup>57</sup> NATIONAL COUNCIL ON EQUALITY FOR WOMEN, Summary Proceedings, *supra* note 54.

<sup>58</sup> NATIONAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 25, at XXXIII.

<sup>59</sup> *Id.*

<sup>60</sup> PROFAMILIA, *¿Por qué se mueren las Mujeres en Colombia?* [Why Do Women Die in Colombia?] in PLANIFICACIÓN, POBLACIÓN Y DESARROLLO [FAMILY PLANNING, POPULATION AND DEVELOPMENT], Vol. 14, No. 28, Santafé de Bogotá, Colombia. December 1996, at 18-19.

<sup>61</sup> NATIONAL COUNCIL OF SOCIAL AND ECONOMIC POLICY, *supra* note 45, at 3.

<sup>62</sup> NATIONAL COUNCIL ON EQUALITY FOR WOMEN, Summary Proceedings, *supra* note 54.

<sup>63</sup> COLOM. CONST., *supra* note 1, art. 42; MINISTRY OF HEALTH, Res. No.08514, 1984. See the preamble of this regulation.

<sup>64</sup> HEALTH FOR WOMEN, *supra* note 38, at 45.

<sup>65</sup> Decree No.1757, 1994, art. 1.

<sup>66</sup> *Id.*, arts. 3-6 and 9-14.

<sup>67</sup> *Id.*

<sup>68</sup> *Id.*, art. 14.

<sup>69</sup> In Colombia, oversight committees, or "veedurias" are organizations, in this case of citizens, charged with supervising public health service delivery and the performance of health care officials.

<sup>70</sup> Decree No.1757, 1994, art. 20.

<sup>71</sup> NATIONAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 25, at 61.

<sup>72</sup> *Id.*

<sup>73</sup> THE ALAN GUTTMACHER INSTITUTE, CLANDESTINE ABORTIONS: A LATIN AMERICAN REALITY, at 20 (1994).

<sup>74</sup> *Id.*

<sup>75</sup> Law No.23, 1981, art. 5.

<sup>76</sup> *Id.*, arts. 4-26.

<sup>77</sup> MINISTRY OF HEALTH, Res. No.08514, 1984, art. 2, § 4.

<sup>78</sup> *Id.*, § 2.

<sup>79</sup> UNITED NATIONS POPULATION FUND, PROGRAMME REVIEW AND STRATEGY DEVELOPMENT REPORT-COLOMBIA (1993) at 23.

<sup>80</sup> *Id.*

<sup>81</sup> *Id.*

<sup>82</sup> Decree No. 1290, 1994. In addition, Decree No. 677, 1995, partially regulates registrations and licenses, quality control, and the safety of drugs, pharmaceutical products made of natural ingredients, and other products, including condoms and diaphragms.

<sup>83</sup> Decree No. 1290, 1994, art. 4.

<sup>84</sup> UNITED NATIONS POPULATION FUND, *supra* note 79, at 23.

<sup>85</sup> *Id.*

<sup>86</sup> *Id.*

<sup>87</sup> *Id.*, at 22.

<sup>88</sup> *Id.*, at 23.

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- 89 NATIONAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 25.
- 90 THE ALAN GUTTMACHER INSTITUTE, *supra* note 73.
- 91 COLOMBIA PENAL CODE, Decree No. 100, art. 343.
- 92 COLOM. CONST., *supra* note 1, art 11.
- 93 Judgement No. C-013/97, Constitutional Court (Jan. 23, 1997).
- 94 PENAL CODE, *supra* note 91, art. 343.
- 95 *Id.*, art. 344.
- 96 *Id.*, art. 345.
- 97 *Id.*, art. 338. In January 1997, the Constitutional Court of Colombia found this law to be constitutional and declared that life is protected from the moment of conception. See Judgment No. C-013/97, Constitutional Court (Jan. 23, 1997).
- 98 *Id.*, art. 343.
- 99 *Id.*
- 100 *Id.*, art. 344.
- 101 *Id.*, art. 345.
- 102 *Id.*
- 103 NATIONAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 25.
- 104 PRESIDENTIAL COUNCIL FOR WOMEN, CHILDREN AND FAMILY. Second and Third Periodic Reports presented before the Committee for the Elimination of All Forms of Discrimination against Women (CEDAW). Bogotá, January 1994.
- 105 PRESIDENT OF THE REPUBLIC OF COLOMBIA, WORLD HEALTH ORGANIZATION, ET AL. 1996: MORTALIDAD MATERNA EN COLOMBIA [1996: MATERNAL MORTALITY IN COLOMBIA].
- 106 *Id.*, at 13.
- 107 *Id.*, at 39.
- 108 *Abortion: Something in Style at the University* in EL TIEMPO, 6 October 1998, at 6A. This article describes the Latin American and Caribbean parliamentary discussions about induced abortions. The discussions were held at the External University of Colombia.
- 109 *Id.*
- 110 *Id.*
- 111 National Department of Statistics, Ministry of Justice. *Iniciación de sumario. Delitos contra la vida y la integridad personal por capítulos del Código Penal* [Cases Initiated: Crimes against life and personal integrity as provided by the Penal Code]. Bogotá, 1994.
- 112 *Latinoamérica aborta por montones* [Latin America aborting in masses] in EL TIEMPO, Bogotá, April 28, 1994.
- 113 *Id.*
- 114 Ministry of Health, Res. 08514, 1984.
- 115 *Id.*, art. 2, § 4.
- 116 *Id.*
- 117 NATIONAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 25, at 46.
- 118 *Id.* at 54.
- 119 *Id.*
- 120 Ruiz, Maga in PROFAMILIA: LA ESTERILIZACIÓN FEMININA EN COLOMBIA. DATOS PROVENIENTES DE ENCUESTAS NACIONALES Y DE PROFAMILIA. [FEMALE STERILIZATION IN COLOMBIA. FACTS STEMMING FROM NATIONAL AND PROFAMILIA SURVEYS.] Bogotá, April 1994.
- 121 *Id.*

122 Decree No. 559, 1991.

123 *Id.*

124 *Id.*, art. 9

125 *Id.*, art. 11.

126 *Id.*, art. 30.

127 *Id.*, art. 29.

128 *Id.*, arts. 13, 16-18.

129 *Id.*, art. 31. In addition, art. 8 establishes that health professional and health establishments cannot deny services to persons infected with HIV/AIDS. If this occurs, the law provides that a penalty will be imposed.

130 *Id.*

131 *Id.*, art. 53. Any person convicted of such a crime must be held in an institution that can assure his or her proper health, psychological and psychiatric care. Any institution that fails to observe this law will be subject to penalties ranging from the imposition of fines to the suspension or loss of the institution's license to provide health services.

132 *Id.*, art. 35.

133 *Id.*, art. 38.

134 MINISTRY OF HEALTH, PROGRAMA NACIONAL DE PREVENCIÓN Y CONTROL DE LAS ETS-VIH/SIDA [NATIONAL PROGRAM TO PREVENT STIs AND HIV/AIDS], at 1 (1995).

135 *Id.*, at 3. The specific objectives of the STI and HIV/AIDS Plan include: to promote greater awareness among the population of issues related to STIs and HIV/AIDS; to reduce morbidity and mortality due to STIs and HIV/AIDS; to decrease the risk of infection of HIV and other STIs; to guarantee respect for persons who are infected with HIV/AIDS or other STIs and to protect their rights; and to strengthen services such as treatment and counseling for persons infected with STIs and HIV/AIDS. *Id.*

136 *Id.*, at 7.

137 *Id.*, at 8.

138 *Id.*, at 29.

139 *Id.*, at 25.

140 United Nations, *supra* note 27, at 47.

141 *Id.*

142 A *tutela* is the brief summary procedure that may be filed by an individual to protect his or her fundamental constitutional rights, in accordance with Article 86 of the Colombian Constitution.

143 Victor de Currea Lugo, *supra* note 31.

144 HEALTH FOR WOMEN, *supra* note 38, at 35.

145 PARTICIPATION AND EQUITY POLICY, *supra* note 45, at 6.

146 NATIONAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 25, at 68.

147 It is also important to note that almost 80% of women of child-bearing age have had sexual relations at some time in their life, as have 30% of women under age 20. See NATIONAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 25, at 73.

148 *Id.*, at 47.

149 *Id.*, at 40.

150 *Id.* Thirty percent of women under age 20 having either no education or some education through the sixth grade have already begun their reproductive life. This percentage compares to only 7% of women having higher levels of education.

151 *Id.*, at 39.

152 *Dialoguemos sobre Salud Sexual y Reproductiva [Let's Talk about Sexual and Reproductive Health]*, Bulletin No. 2,

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March 1998, at 3.

153 NATIONAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 25, at 39.

154 *Id.*

155 MUÑOZ, MONTSERRAT. INFORME NACIONAL A LA REUNIÓN REGIONAL DE AMÉRICA LATINA SOBRE SALUD SEXUAL Y REPRODUCTIVA DE LOS ADOLESCENTES COLOMBIANOS [NATIONAL REPORT TO THE REGIONAL MEETING ON THE SEXUAL AND REPRODUCTIVE HEALTH OF ADOLESCENTS] at 13 (1997).

156 COMITÉ INTERINSTITUCIONAL PARA LA REVISIÓN DE LOS PROCEDIMIENTOS DE ATENCIÓN A LAS MUJERES VÍCTIMAS DE VIOLENCIA SEXUAL [INTER-INSTITUTIONAL COMMITTEE FOR THE REVISION OF LEGAL PROCEDURES IN ATTENDING FEMALE VICTIMS OF SEXUAL VIOLENCE]. DERECHO, ORDENAMIENTO LEGAL Y PROCESO JUDICIAL, [LAW AND THE JUDICIAL PROCESS] with regard to sexual crimes against minors between 14 and 18 years of age and minors under 14 years of age.

157 COLOM. CONST., *supra* note 1, art 42.

158 CIVIL CODE, bk. I, tit. IV.

159 *Id.*, art. 113.

160 *Id.*, art. 115.

161 *Id.*, art. 116.

162 Decree Law No. 999, 1988, eliminated the legal requirement that a woman use her husband's surname, preceded by the word “*de*” (“of”) on her citizenship documents.

163 CIVIL CODE, art. 176.

164 *Id.*, art. 177.

165 *Id.*, art. 179.

166 Parental authority denotes the series of rights recognized by law that parents have over their minor children. See CIVIL CODE., art. 288.

167 *Id.*

168 *Id.*, art. 306.

169 Law No. 28, 1932, and Decree No. 2820, 1974.

170 Law No. 258, 1996.

171 Law No. 54, 1990, art. 1.

172 *Id.*

173 Law No.54, 1990, art. 3.

174 *Id.*

175 Law No. 100 of 1993, art. 47. See also NATIONAL COUNCIL ON EQUALITY FOR WOMEN, LOS DERECHOS DE LA MUJER EN COLOMBIA [THE RIGHTS OF WOMEN IN COLOMBIA] 134 (Mar. 1997).

176 Law No. 100 of 1993, art. 236.

177 NATIONAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 25, at 70.

178 *Id.*, at XXXIII.

179 *Id.*, at 70.

180 *Id.*, at 71.

181 United Nations, *supra* note 27, at 68.

182 Law No.25, 1992, art. 5.

183 *Id.*

184 CIVIL CODE, art. 154, modified by Law No.25, 1992, art. 6.

185 The regulations on the dissolution of joint ownership of property of spouses is found in CIVIL CODE, bk. 4, tit. XXII, chs. I-IV.



- 186 *Id.*, art. 183.
- 187 *Id.*, art. 162.
- 188 *Id.*, arts. 161 and 151.
- 189 *Id.*, art. 151 and 411. Child support is considered to be the minimum amount required for the sustenance, shelter, clothing, medical assistance, recreation, and comprehensive education of an individual. Alimony is granted in some cases using similar guidelines.
- 190 *Id.*, arts. 161 and 411.
- 191 PENAL CODE, *supra* note 91, art. 263. In other words, when a person is required to pay alimony or child support but fails to pay it without just cause.
- 192 Decree No. 2727, 1989.
- 193 Law 311 of 1996, article 1.
- 194 CIVIL CODE, article 154.
- 195 *Id.*, art. 116, modified by Decree No. 2820, 1974, art. 2.
- 196 *Id.*, art. 117.
- 197 *Id.*, art. 140.
- 198 *Id.*, art. 143.
- 199 NATIONAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 25, at 66.
- 200 It is important to note that in a recent study, however, only 2% of women who did not use family planning methods reported that they did so because their husbands or partners opposed it. The percentage of women refusing such methods for religious reasons was 1% to 2%. See NATIONAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 25, at 61.
- 201 On February 7, 1997, the Colombian Congress passed Law No. 360, 1997.
- 202 Previously, such crimes were classified as crimes “against freedom and sexual decency.” See PENAL CODE, *supra* note 91, bk. II, tit. XI.
- 203 *Id.*, arts. 298-300, modified by Law No. 360, 1997, arts. 2-4.
- 204 *Id.*, arts. 303-305, modified by Law No. 360, 1997, art. 204.
- 205 *Id.*, arts. 301 and 302. Statutory rape is classified as a crime involving carnal access or other sexual acts with a person under the age of 18 through the use of deceit. For a more detailed description, see the section on adolescents below.
- 206 Law No. 360, 1997, art. 2. In penal law, “carnal access” is a sexual act that includes the realization of coitus.
- 207 *Id.*, art. 3. A sexual act is defined as all acts of a sexual nature other than carnal access.
- 208 *Id.*, art. 4.
- 209 *Id.*, art. 6. Abusive carnal access is the rape of an individual who is unconscious, who suffers from a psychological impediment, or who is otherwise incapable of resisting.
- 210 PENAL CODE, *supra* note 91, art. 306.
- 211 *Id.*
- 212 *Id.*
- 213 *Id.*
- 214 Law No. 360, 1997, art. 8.
- 215 Law No. 294, 1996, art. 25. The penalty for this crime is six months to one year imprisonment. A criminal trial takes place only when the victim brings a lawsuit against the offender.
- 216 PENAL CODE, *supra* note 91, tit. XI.
- 217 *Id.*, art. 303, modified by Law No. 360, 1997, art. 5.
- 218 *Id.*, art. 290, modified by Law No. 360, 1997, art. 2.

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- 219 *Id.*, art. 305, modified by Law No. 360, 1997, art. 7.
- 220 *Id.*, arts. 301 and 302.
- 221 *Id.*, art. 301.
- 222 *Id.*, art. 302.
- 223 *Id.*, Tit. IX.
- 224 *Id.*, art. 259.
- 225 *Id.*
- 226 *Id.*, art. 312, modified by Law No. 360, 1997, art. 12.
- 227 *Id.*, art. 312bis, modified by Law No. 360, 1997, art. 13.
- 228 *Id.*, arts. 312 and 312 bis.
- 229 Decree 1974, 1996.
- 230 NATIONAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 25, at XXXI.
- 231 *Id.*
- 232 *Id.*
- 233 PROFAMILIA, *Violación a las mujeres en Colombia [Rape in Colombia]* in PLANIFICACIÓN, POBLACIÓN Y DESARROLLO [FAMILY PLANNING, POPULATION AND DEVELOPMENT], Vol. 14, No. 27, June 1996, at 45.
- 234 *Id.*, at 46. The “other” category included prior husbands or partners, the father of the first child, godfathers, and tenants. In other words, these “others” were known by the women.
- 235 *Id.*
- 236 *Id.*, at 49.
- 237 NATIONAL COUNCIL ON EQUALITY FOR WOMEN, LOS DERECHOS DE LA MUJER EN COLOMBIA, *supra* note 175, at 47.
- 238 PROFAMILIA, *Violación a las Mujeres en Colombia*, *supra* note 233, at 46.
- 239 *Id.*
- 240 *Id.*
- 241 *Id.*, at 49.
- 242 National Reference Center on Violence, National Institute of Legal Medicine and Forensic Sciences. CRNV Bulletin Vol. 3, February 1998, at 6.
- 243 NATIONAL COUNCIL ON EQUALITY FOR WOMEN. INVESTIGACIÓN SOBRE LA APLICACIÓN DE LA LEY DE VIOLENCIA INTRAFAMILIAR [INVESTIGATION OF THE IMPLEMENTATION OF THE LAW ON FAMILY VIOLENCE], 1998, at 67.
- 244 LAW AND THE JUDICIAL PROCESS, *supra* note 156.
- 245 *Id.*
- 246 Proposed law that would reform the Penal Code and Procedures.
- 247 *See* Supreme Court Decision, Court of Appeals, May 22, 1992. (Presiding judge: Gustavo Rendón Gaviria.)
- 248 COLOM. CONST., *supra* note 1, art. 42.
- 249 Law No. 248, 1995.
- 250 *See* Law No. 294, 1996, art. 1.
- 251 *Id.*, art. 22.
- 252 *Id.*, art. 23; Articles 331-341 of the Penal Code define different types of injuries as crimes and establish penalties according to the degree of severity of the injuries inflicted.
- 253 *Id.*, art. 24. This crime is called “abuse through the restriction of physical freedom.”
- 254 *Id.*, arts. 4-5.
- 255 The Colombian Institute of Family Welfare is the entity charged with protecting the family. Specifically, it

devises programs aimed at abused children and abused mothers with limited economic means. It also provides foster care for children under five. *See* PRESIDENTIAL COUNCIL FOR SOCIAL POLICY, *supra* note 5, at 34.

256 Law No. 294, 1996, arts. 28-29

257 *Id.*, art. 28.

258 NATIONAL DEVELOPMENT PLAN, THE SOCIAL LEAP FORWARD, *supra* note 41.

259 These represent 2% of homicides.

260 National Reference Center on Violence, National Institute of Legal Medicine and Forensic Sciences. CRNV Bulletin Vol. 3, No. 5, May 1998, at 6.

261 NATIONAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 25, at 157.

262 *Id.*, at XXXI.

263 NATIONAL COUNCIL ON EQUALITY FOR WOMEN, LOS DERECHOS DE LA MUJER EN COLOMBIA, *supra* note 175, at 47.

264 NATIONAL DEMOGRAPHIC AND HEALTH SURVEY, *supra* note 25, at XXXI. *See also* at 157. This number is higher than that recorded in 1990. In that year, only 11% of abused women filed complaints.

265 HEALTH AND DEVELOPMENT CORPORATION, VIOLENCIA EN COLOMBIA, RETOS Y PROPUESTAS DESDE EL SECTOR SALUD [VIOLENCE IN COLOMBIA: CHALLENGES AND PROPOSALS FROM THE HEALTH SECTOR] (November 1997).

266 National Reference Center on Violence, National Institute of Legal Medicine and Forensic Sciences. CRNV Vol. 3, No. 4, April 1998.

267 National Reference Center on Violence, National Institute of Legal Medicine and Forensic Sciences. CRNV Bulletin Vol. 3, No. 5, May 1998.

268 *Id.*

269 Law 294 of 1996, Title II.

270 *Id.*, Title IV.

271 NATIONAL COUNCIL ON EQUALITY FOR WOMEN, INVESTIGATION OF THE IMPLEMENTATION OF THE LAW ON FAMILY VIOLENCE, *supra* note 243, at 58.

272 *Id.*, at 15.

273 NATIONAL COUNCIL ON EQUALITY FOR WOMEN, Summary Proceedings, *supra* note 54.

274 COLOM. CONST., *supra* note 1, art 44. The Constitution also states that children born both in and out of wedlock, and those conceived naturally or by artificial means have equal rights and duties. *Id.*, art. 42.

275 PRESIDENCY OF THE REPUBLIC OF COLOMBIA, COLOMBIA PAGA SU DEUDA A LAS MUJERES. INFORME NACIONAL DEL GOBIERNO DE COLOMBIA. CUARTA CONFERENCIA MUNDIAL SOBRE LA MUJER [NATIONAL REPORT FROM COLOMBIA. NATIONAL REPORT OF THE COLOMBIAN GOVERNMENT. FOURTH INTERNATIONAL CONFERENCE ON WOMEN], at 11 (1995).

276 COLOM. CONST., *supra* note 1, art. 67.

277 *Id.*

278 INSTITUTIONAL SUPPORT OF THE POLICY OF EQUITY AND PARTICIPATION FOR WOMEN, *supra* note 43, at 27.

279 *Id.*

280 NATIONAL REPORT FROM COLOMBIA, *supra* note 275, at 21.

281 United Nations, *supra* note 27, at 26.

282 *Id.*

283 *Id.*

284 NATIONAL REPORT FROM COLOMBIA, *supra* note 275, at 21.

285 United Nations, *supra* note 27, at 61. In 1990, the female population in rural areas had an average of 3.2 years of education, compared to 5.8 years for women in urban zones. Among rural women, 13.9% have no education

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at all, while the number in urban zones is 6.3%. As to primary education (the first six years of school), 40.2% of rural women have had primary education, while 60% of urban women have done so. As to secondary education, 12.9% of rural women have completed at least one year, while 35% of urban women have done so. Finally, as to higher education, 0.5% of rural women have completed higher studies, compared to 7.5% of urban women.

<sup>286</sup> Res. No. 03353, July 2, 1993, which establishes the creation of institutionalized sex education programs in the national educational curriculum.

<sup>287</sup> *Id.*

<sup>288</sup> MINISTRY OF EDUCATION, PROYECTO NACIONAL DE EDUCACIÓN SEXUAL [NATIONAL PROJECT ON SEX EDUCATION], at 1 (1993).

<sup>289</sup> *Id.*

<sup>290</sup> *Id.*

<sup>291</sup> *Id.*

<sup>292</sup> *Id.*, at 4-5.

<sup>293</sup> *Id.*

<sup>294</sup> MINISTRY OF EDUCATION, VICEMINISTRY OF ADOLESCENTS, PROYECTO DE EDUCACIÓN EN SALUD SEXUAL Y REPRODUCTIVA DE JÓVENES Y PARA JÓVENES [PROPOSED PROGRAM ON SEXUAL AND REPRODUCTIVE EDUCATION OF ADOLESCENTS AND FOR ADOLESCENTS].

<sup>295</sup> *Dialoguemos sobre Salud Sexual y Reproductiva*, *supra* note 152, at 4.

<sup>296</sup> CIJUS, Center of Social and Legal Investigations. OBSERVATORIO DE LA MUJER. Santafé de Bogotá, 42 (Universidad de los Andes, September 3, 1998).

<sup>297</sup> COLOM. CONST., *supra* note 1, art. 25.

<sup>298</sup> *Id.*, art. 53.

<sup>299</sup> *Id.*, art. 48; Law No. 100, 1993.

<sup>300</sup> LABOR CODE (Law No. 50 of 1990), art. 239.

<sup>301</sup> *Id.* In order to terminate a woman's employment during pregnancy or in the three months following childbirth, the employer must receive authorization from the labor inspector or the mayor. *See also* arts. 240 and 241.

<sup>302</sup> *Id.*, arts. 240 and 241.

<sup>303</sup> Res. No. 4050, 1994, art. 2.

<sup>304</sup> *Id.*, art. 3.

<sup>305</sup> Res. No.02400, May 1979.

<sup>306</sup> OFFICE OF THE OMBUDSMAN, FOURTH ANNUAL OMBUDSMAN'S REPORT BEFORE THE COLOMBIAN CONGRESS, at 457.

<sup>307</sup> *Id.*

<sup>308</sup> CIJUS, *supra* note 296.

<sup>309</sup> MINISTRY OF EMPLOYMENT. DIAGNOSTIC EXAM ON EMPLOYMENT DISCRIMINATION AGAINST WOMEN IN COLOMBIA. Santafé de Bogotá, at 99 (1997).

<sup>310</sup> *Id.*

<sup>311</sup> *Id.*

<sup>312</sup> *Id.*

<sup>313</sup> OFFICE OF THE OMBUDSMAN, *supra* note 306, at 475.

<sup>314</sup> *Id.*, at 483.

<sup>315</sup> *Id.*

<sup>316</sup> LABOR CODE, art. 236.

<sup>317</sup> *Id.*

<sup>318</sup> *Id.*

<sup>319</sup> *Id.*, art. 238.

<sup>320</sup> *Id.*, art. 237.

<sup>321</sup> *Id.*

<sup>322</sup> Constitutional Court, Sentences T-694 of 1996; T-119 of 1997; and T-44 of 1994.